TECHNICAL ADVISORY COMMITTEE

ON PHARMACY

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Cabinet for Health and Family Services

275 East Main Street

Cafeteria Conference Room

Frankfort, Kentucky

Meeting held on

September 17, 2019,

Commencing at 9:30 a.m.

Tamara S. Duvall-McClain, RPR

A T T E N D A N C E

PHARMACY TAC MEMBERS:

Suzanne Francis, Chair
Christopher Betz
Matt Carrico
Cynthia Gray
Paula Miller

APPEARANCES:

Sharley Hughes, Medicaid Services

Jessin Joseph, Medicaid Services

Joe Vennari, Humana CareSource

Chris Palutis, Kentucky Pharmacists Association

Mark Glasper, Kentucky Pharmacists Association

Andrew Rudd, Anthem

April Cox, Aetna

Carrie Armstrong, Passport

Thea Rogers, WellCare

David Gray, Medicaid Services

MS. FRANCIS: Okay. So, I will go ahead and kick us off. Thank you everyone for being here. So, I'm excited about this meeting, we have a jam-packed agenda. And there was even one item on the agenda I forgot to put on there, which I handwrote on, and we'll get to that on new business.

But I'm Susie Francis, and I'm the Chair of the PTAC from St. Elizabeth Health Care in northern Kentucky.

MR. BETZ: Christopher Betz, Professor, Sullivan University College of Pharmacy and Health Sciences. They yell at me when I don't put that part in there. And PTAC member.

MR. CARRICO: Matt Carrico, Booneville Discount Drug, PTAC member.

MS. HUGHES: Sharley Hughes from Medicaid.

MR. JOSEPH: Jessin Joseph, Medicaid.

MR. VENNARI: Joe Vennari, Humana CareSource.

MR. RUDD: Andrew Rudd, Anthem.

MR. PALUTIS: Chris Palutis, Chair of the Board of Directors for Kentucky Pharmacist Association and I own two pharmacies here.

MR. GLASPER: Mark Glasper, Executive

Director, KPhA.

MS. ARMSTRONG: Carrie Armstrong, Pharmacy Director with Passport.

MS. ROGERS: Thea Rogers, WellCare.

MS. PATEL: Dauerti Patel. I'm a UK student here on rotation.

MS. GRAY: Cindy Gray, Diamond Pharmacy, PTAC member.

MS. MILLER: Paula Miller from Ruwe Pharmacy in northern Kentucky and a PTAC member.

MS. HUGHES: And the Commissioner would be here, but she has a family emergency and had to be out for a little bit, so she's sorry she can't join us today.

MS. FRANCIS: Okay. So, she'll review the minutes I'm sure.

MS. HUGHES: Yes, she will.

MS. FRANCIS: All right. Well, I hope that everything's okay.

Oh, April, come on in. So, we'll go ahead and get started here. This is April Cox from Aetna.

MS. COX: Hello.

MS. FRANCIS: Okay. So, first of all, the approval of the July 23rd minutes. And I sent

those out prior to. I did not have any suggested edits or clarifications from them. Did anybody else on the PTAC?

So do we have approval?

MR. BETZ: Yes, motion to approve.

MS. FRANCIS: Chris.

MS. GRAY: Second.

MS. FRANCIS: Okay, Chris and Cindy approve those.

And so we'll go ahead. I'd like to get an update, I guess I'll defer to Jessin --

MR. JOSEPH: Sure.

MS. FRANCIS: -- from DMS. I had some follow-up items from the previous --

MR. JOSEPH: Sure, yeah.

MS. FRANCIS: -- minutes, but then, also, if you have anything else, please.

MR. JOSEPH: Sure. So, we'll just go off here. The co-pays, we're still looking into it right now. The system on KyHealth.net allows you to see whether or not the patient's met the cost share, but the number isn't there. So the number is actually calculated on the back end, it's not available right now on the actual patient portal -- or the provider portal. I don't know if that

number will be provided on the patient portal.

That said, I have had a pharmacist reach out to me about the data being inaccurate. So, I'd just like to ask if anybody uses -- if any pharmacist used KyHealth.net, and, if so, is that data inaccurate, and if you can send me examples.

MS. MILLER: Just the data about --

MR. JOSEPH: The data about the patient, the MCO that they belong to, the eligibility, just pretty much everything on KyHealth.net. The pharmacist, when he reached out, it was kind of a blanket statement that it wasn't working for him, but he didn't give me any examples, so -- and this was yesterday.

MR. VENNARI: How would he know that it was inaccurate?

MR. JOSEPH: So, he said the patient had an MCO on the website, on KyHealth.net, and then when he tried to run the insurance it did not. So, it was saying that that patient wasn't correct and that was it. So, again, it was very generic in terms of who it was, which MCO it was. So my worry is, is KyHealth.net inaccurate.

MS. FRANCIS: So as far as the pharmacy ID numbers for MCOs, they are loaded on there, Paula

checked. Would you like us to send anything out to pharmacists that says you can use KyHealth.net as a resource. If you find anything --

MR. JOSEPH: Yes. Yes, they are -- every pharmacist, every provider is more than welcome to use KyHealth.net. But if there is an error that comes up, what I would just need is the patient ID and the specific problem, because otherwise I don't know where to start.

MS. FRANCIS: Do you want us to have them directly e-mail you?

MR. JOSEPH: Yeah, yeah, they're more than welcome to.

MS. FRANCIS: Okay, secure e-mail.

MR. JOSEPH: Yeah.

MS. FRANCIS: Okay. Mark, do you think we can send something out on that?

MR. GLASPER: Certainly. Can we add what it's used for? Because I've been a pharmacist in this state for over ten years and I don't -- I've never known that I could go on KyHealth.net.

MS. FRANCIS: So, they have a new website, so it just was launched and so there is more --

MR. JOSEPH: It was supposed to be for Kentucky Health --

MS. FRANCIS: Yeah.

MR. JOSEPH: -- and then it just transitioned.

MR. GLASPER: Okay, good. I kind of felt bad about --

MS. FRANCIS: No, it was just --

MS. HUGHES: Yeah, it's been in existence for 50 years.

MR. GLASPER: I was feeling really bad.

MS. FRANCIS: It should be more user friendly for us frontline with patients. Like Paula had suggested to David Gray, who was helping launch that site in the Cabinet, to put the pharmacy ID numbers on there, because, you know, sometimes they're not accurate on their card, too, but -- or they don't have a card. So, you're -- you can look up a patient on the KyHealth.net site and get their MCO or Medicaid ID, and so that is on there now. But we want to make sure that that is accurate.

MR. JOSEPH: Yeah. And it's only been one person that's reached out, so I just wanted to make sure that --

MR. PALUTIS: Like is it a pharmacy that registers or anybody has access to it?

MR. JOSEPH: My understanding it's any provider, right?

MS. HUGHES: Any provider has access to it. That way --

MR. JOSEPH: You as Chris Palutis can register. I don't think it's going to be based off your pharmacy.

MR. PALUTIS: Okay.

MS. MILLER: You can see if they're QMB or you can find out if they have coverage.

MR. GLASPER: Yeah, that's really helpful.

MS. MILLER: It is, it's really helpful. It's just not very user friendly. It is helpful.

MR. JOSEPH: Yes. And I'm just hoping that the content is still accurate, so --

MS. FRANCIS: I think it would be a good idea, it would help patient care, if we alerted pharmacists, first of all, that this resource is there.

MR. JOSEPH: Sure.

MS. FRANCIS: And let them know what they can go to look for it on. I don't know if that would be something, Jessin, if you could put how you want that worded, what information, and send that to Mark.

MR. JOSEPH: Yeah, I was going to say that would probably be the best way. I'll send something over to you and you can just send it out.

MR. GLASPER: That's great, thank you.

MR. CARRICO: But it does show how much out of pocket they have or how much left until they have no co-pay that quarter?

MR. JOSEPH: It has an indicator. So, it has a yes or no whether or not they met their cost share. It doesn't tell you the amount.

MR. CARRICO: It doesn't tell you if they're close or not, just yes, no?

MR. JOSEPH: Yeah.

MR. CARRICO: And it's quarterly, correct?

MR. JOSEPH: It's updated -- yes, the cost share is quarterly, but it's updated every night.

MR. CARRICO: What's the reasoning for going quarterly?

MR. JOSEPH: That's a good question.

MS. HUGHES: It's federal statute. It says the 5 percent limit on cost sharing is a federal -- is part of the federal Medicaid statute.

MR. CARRICO: Okay.

MS. HUGHES: And it's done on a quarterly basis.

MR. CARRICO: Got you.

MS. HUGHES: Because a lot of times their income changes during that quarter, so --

MR. CARRICO: That makes sense.

MS. FRANCIS: It's KyHealth.net?

MR. JOSEPH: Yes. Is that right?

MS. HUGHES: Yes.

MR. JOSEPH: KyHealth, okay.

MS. HUGHES: And it is KyHealth.net.

MS. FRANCIS: That's correct.

MS. HUGHES: Okay.

MS. FRANCIS: Sorry, yes, KyHealth.net. It might even be helpful to have a little tip sheet how to navigate that, especially for pharmacists, where we want to go to. Because I went on there first and --

MS. MILLER: Were you lost?

MS. FRANCIS: I was a little lost, yeah.

MS. MILLER: There's Medicaid numbers and case numbers and --

MR. JOSEPH: Okay. I can ask our team, see if we can put together kind of a one pager for that.

What might be beneficial is, Paula, if I can reach out to you about --

MS. MILLER: Sure.

MR. JOSEPH: -- what you're using it for and then we can just tailor it to what we think pharmacists would be using it for. Awesome, so that's co-pays.

In terms of SB 5 data, we're still collecting all the MAC rates. Again, we're ensuring that the MACs are at least above net ac, and then we try to adjust for the price of the drug. So, we try to go -- you know, depending on price, we'll go a little bit above net ac, and then we try to account for the dispensing fee.

So, I do have a meeting scheduled today with another pharmacist in the state around some reimbursement rate issues. Most of them are approved. My worry is if a PBM -- if we disapprove a rate and a PBM does not apply that dis- -- or they don't go back to the old rate, how are we able to know that. Medicaid won't be able to know that unless pharmacists reach out and show us. And so he's reached out. And so we're just going to have a conversation about what we do on our end when we get these sort of reports and then

what we can do moving forward.

But, yeah, that, and then along with a couple of the MCOs moving to new PBMs. We're going to ensure that all the rates that come out initially are going to be appropriate before they go live. So, we're working with minor stuff around that. And it should be good for the 10-1 go live date for Anthem, and then the 1-1 go live date for Humana.

MS. FRANCIS: Okay. So at last -- at last meeting the Commissioner had said future research would -- she would need -- she would want future research for the dispensing fee, plus ingredient cost from chains, from independent pharmacies, from specialty pharmacies, and everything that would go into that, including clinical time or whatnot. So, we're not to that point yet.

MR. JOSEPH: No.

MS. FRANCIS: But she will alert us I guess.

MR. JOSEPH: Yeah, I would think she would alert you. Yeah, right now, I mean, we're still -- so, we are collecting the dispensing fees. We don't see a discrepancy between them, between the chains and the retail -- or the chains and the

independent stores. We do just know inherently that the MCO dispensing fees are lower than the fee for service dispensing fee. But comparatively across the types of pharmacies we don't see an issue that needs to be addressed as of yet.

I think what we'll need to do is once we have this moderate program set in place, then we can do a deep dive into ingredient cost on that end and less so on the dispensing fee. Again, most of that's contractually set up by the PBM and the pharmacy. So, we can do a deep dive, but what we're seeing right now is what was set up in the contracts.

MR. PALUTIS: Set up contractually, but couldn't -- couldn't there perceivably be a different set of data for, for example -- and I'm not saying that this is the case, I'm just saying --

MR. JOSEPH: Yeah.

MR. PALUTIS: -- so the contract says AWP minus a percent, plus a dispensing fee for a brand or generic that's not MAC. Then says MAC plus dispensing fee for all MAC items. I'm sure that contract language is probably standard across the board, but are they -- is it possible that they

would have different lists of drugs with different MACs for different groups of pharmacies that they contract with as providers?

MR. JOSEPH: Yes, 100 percent.

MR. PALUTIS: Okay. So that's what you're going to look into.

MR. JOSEPH: Yeah.

MR. PALUTIS: The contracts look the same, but that doesn't mean they're being disbursed the same.

MR. JOSEPH: Yeah. So the dispensing fee, though, won't change on those.

MR. PALUTIS: Right.

MR. JOSEPH: What's different on those contracts is the ingredient cost. So, it will be the MAC and the AWP or the percentage off the AWP, but yeah.

MS. FRANCIS: And for clarification, on the minutes last time, Commissioner said that there won't be any post-adjudication fee starting July, 2020.

MR. JOSEPH: Yes.

MS. FRANCIS: Can we explain how that's going to work a little bit or --

MR. JOSEPH: Yeah. So, we're,

essentially, forcing our MCOs and PBMs to go back to a MAC contract, so you only pay the maximum level cost and there is no way for -- or we're disallowing the direct and indirect remuneration fees that we see right now. The reason it's going live on July 1, 2020, is when the new MCO contract starts, so --

MS. FRANCIS: Okay.

MR. JOSEPH: -- instead of implementing it in the middle of a contract, it's just easier.

MS. FRANCIS: At the point of sale the pharmacy will know their reimbursement.

MR. JOSEPH: That is our expectation. That is our expectation with the contract language.

MR. PALUTIS: I'm sorry to keep talking, but I was going to bring this up later. Was there some kind of letter that went out --

MR. JOSEPH: Yeah.

MR. PALUTIS: -- that said -- because what concerns me is that if I'm the PBM, I mean, I'm just being honest, if I'm the PBM and you're allowing me to take 4 -- you know, anything less than 5 percent after it is all said and done, I'm going to take it. And so if you do 4.9 percent of

the claims, even if it's an average of 40 bucks, it's like $50 million that they could bring back after the product is already gone and the service is provided.

MR. JOSEPH: So, we did put a disallowance for all PBMs from any GER, BER, any type of effective rate greater than 5 percent on a specific claim from going through.

MS. FRANCIS: At the point of sale.

MR. JOSEPH: At post point of sale. So this is -- this -- right now we're monitoring at point of sale, like the MAC monitoring process is for the point of sale. What we did is we, basically, sent out a blanket statement for regardless of if you think the effective rate is going to help you or if it's going to hurt you, we are not allowing anybody to adjust greater than 5 percent.

Your point is still valid, they can change at less than 4.9 percent. I would be hesitant if they do, because, one, they would have to change their systems to accommodate something like that. I'm not saying it's impossible, but, you know, I'm just doubtful of them doing something like that. And just from the report that we've now had with

some of the PBMs, it's much easier to understand that they're trying to ensure that everybody is paid a little bit more fairly.

And I understand everyone's hesitation around that, but if we do see anything like that -- or if you see anything like that, because we won't see it, right, we don't have the ability to see the the post-adjudicated claims. So if you are seeing anything like that, I would say request your analysis from your PSAO or from your PBM at a claim level and then we can take a look from there. We know that they can do it at claim level, they are. The PSAOs don't necessarily want to do it at the claim level, but the contract is set up to be done at claim level. So, you can get it at claim level and then we can take a look from there, but --

MR. PALUTIS: Because if they -- you know, I'm not telling them how to do business, but they're smart people. If they take that $50 million, and maybe they don't take it away from a Medicaid claim, but they put it in their pool or bucket, that gets you to a lower GER, right.

MR. JOSEPH: Yeah.

MR. PALUTIS: I mean, it's still state

money that they're using to offset what they reimburse us for other product, which is kind of still --

MR. JOSEPH: Yeah.

MR. PALUTIS: -- we don't want to see happen. But my understanding is that they pool all this money across the claims, and so where -- where does it all come from. And if they can take 4.9 percent of every Medicaid claim they pay --

MR. JOSEPH: Yeah, oh, I agree. I mean, there's more downstream effects of that beyond just how they affect the GER, down to how we pay the MCOs. So, we're aware of it, but we're trying to --

MS. FRANCIS: Okay, we'll monitor it.

MR. JOSEPH: Yeah.

MS. FRANCIS: Okay. So anything else? Do you have an ETA of --

MR. JOSEPH: Of the?

MS. FRANCIS: -- of when you think that you're going to be finished with the data collection and report, I guess, for --

MR. JOSEPH: So, we can do an update to the last spread report, which still takes into account the ingredient cost and dispensing fees

for the chains, the independents, and the specialty pharmacies. I don't know how beneficial that will be, because the numbers have stayed pretty much consistent across the board. We looked at, when we first ran the analysis, for a full year. And now that it's been about a year and eight months, the data's stayed pretty consistent around that value, 12 percent on the spread. And then the dispensing fees haven't increased. And the ingredient costs have trended as we would expect them to trend just due to market.

But, I mean, if a report is what you're looking for or an update to the report, we can put something together if that's --

MS. FRANCIS: I think there is just, in the pharmacy world, probably a desire to hear, since there has been so much --

MR. JOSEPH: Sure.

MS. FRANCIS: -- legislation, publication --

MR. JOSEPH: Sure.

MS. FRANCIS: -- media about this, and just to say this is the findings and --

MR. JOSEPH: Well, that's what I'm

stressing, the February report was the findings of the original analysis, and we're not seeing much change from the February report.

MS. FRANCIS: Okay.

MR. JOSEPH: So, I don't want to -- I don't want to not do -- I mean, I'm glad to do it, I just would say that what we've --

MS. FRANCIS: I'm just bringing it up as Chair, I don't --

MR. JOSEPH: Yeah.

MS. FRANCIS: You know, I would defer --

MR. JOSEPH: I don't have a problem putting something together. We'll just give you guys an update where we still are. I think we may have done it for the May committee meetings.

MS. HUGHES: Oh, the MAC, yeah.

MR. JOSEPH: The May MAC meeting, I think we put together a report what we were seeing through five months.

MS. FRANCIS: All right. Anyone else have anything about Senate Bill 5?

And then I just -- the last item on there was the open meeting, so --

MS. HUGHES: Oh. And I don't want you-all to be scared to death. I had a TAC meeting the

other day and they were like ahhh. I said it's not as bad as you-all think. The bottom line is the Open Meetings Law is meant to prevent any committee, any board, anybody like that from conducting business not in the public view. So like, for instance, at a TAC meeting the other day, somebody from the association told the MAC members -- or the TAC members if you-all can think of anything you want to make a recommendation for, just send it to me and I'll write it up and we'll present it to the MAC. And I'm like no, no, no, no, you can't do that. Your recommendations need to be brought up here, they need to be voted on here and so forth.

So there is a question, because it does state that you can't conduct business via e-mail; I know we do stuff via e-mail, you know. I'm waiting to get more clarification from our general counsel. As far as like for agenda items and stuff like that, I don't think that's an issue, you know, sending out an e-mail and saying what do you -- you know, do you have anything you want to put on the agenda.

MS. FRANCIS: Right.

MS. HUGHES: But if you're wanting to, you

know, send an e-mail and saying stuff like, you know, so-and-so talked about the 340, you know, or something like that just as an example, you know, what do you-all think, blah, blah, blah, and you're all talking about it via e-mail, that technically could be a --

MS. FRANCIS: If we had a workgroup, a sub-workgroup from the Pharmacy TAC --

MS. HUGHES: Uh-huh.

MS. FRANCIS: -- do we need to publish that meeting and things like that?

MS. HUGHES: Yes. Yes, any subgroup of the committee would have to be meeting in public and would have to make the public aware that meetings are going on.

MS. FRANCIS: Okay. And one thing we are -- KPhA was going to help us with is any agenda items. We were going to send an e-mail blast out through KPhA for any pharmacy-related acts, potential agenda items. To me that helps meet the open law requirements.

MS. HUGHES: Right.

MS. FRANCIS: Is there anything wrong with that?

MS. HUGHES: Well, that's one of the

things I'm getting clarification on. Going back, that was what one of the TACs last week brought up, you know, can we not send out e-mails asking for agenda items.

MS. FRANCIS: I mean, it's unrealistic to think that pharmacists in the state could attend this meeting.

MS. HUGHES: Right, right.

MS. FRANCIS: So, they would have to read minutes of --

MS. HUGHES: Right, exactly. So, you know, the law was, obviously, created back before e-mail and all this stuff. So, I think bottom line is they don't -- we just want to ensure there's not actual business being conducted outside of the meetings. And -- now, if -- this is not to say that Kentucky Pharmacy Association cannot create a committee to discuss something. And you-all may all be on it, and that's fine. Because that's them forming a committee, it's not the state forming a committee.

MS. FRANCIS: Okay.

MS. HUGHES: What you can't do is if you're at that gathering, the five of you-all can't start talking, doing business talking about

the TAC business at that meeting.

MS. FRANCIS: Okay.

MS. HUGHES: So, they're just -- you-all are not going to be familiar with it because you're not state employees or you've not had to go through this. And we did know that there was a couple of TACs, not this one, that was doing some things that were obviously breaking the Open Meetings Law, so that was the reason for that.

And I'm going to send out some more information once I get -- our attorneys let me know on the e-mailing. I don't have a problem with it, but then I'm not the one that enforces the laws, you know.

MS. FRANCIS: To me it's more open if I have the pharmacist association send out, you know, hey, you have a Pharmacy TAC that meets. If you have concerns, or issues, or comments for the state, for DMS --

MS. HUGHES: Right. And personally, I don't think that any state agency could say to the Kentucky Pharmacy Association or any other association you can't send out a memo or an e-mail blast asking for suggested items, you know, at a meeting. That's them doing it. I don't think we

could do that, you know, we couldn't -- personally, I don't think we can.

MR. GLASPER: My only question would be do we then take that information, those requests, those questions --

MS. HUGHES: Right.

MR. GLASPER: -- do we take them and submit them to PTAC ahead of time to put on the agenda --

MS. HUGHES: Right.

MR. GLASPER: -- or do we hold that information until the meeting?

MS. HUGHES: Right. And that's the part I'm trying to get. Because I don't see how they at this point in time in the world, when everything is done electronically, that they could really say a lot. So, I'm trying to not -- till I have an attorney say to me, no, they can't even send an e-mail about the agenda, I don't want to -- you know, to say you can't do that, so --

MS. GRAY: The agenda is not conducting business though.

MS. HUGHES: No, that's not conducting business. It's if you're, you know, like, for instance, you know, hey, if you-all got a recommendation, if you think of something you want

to recommend, send it to me and I'll type it up, present it to the MAC.

MS. FRANCIS: Yeah. And we always bring it here.

MS. GRAY: Yeah.

MS. HUGHES: Right. That's definitely not conducting business of the TAC in an open meeting forum, so --

MS. FRANCIS: Okay. I don't -- I think it would be a good idea to proceed with KPhA.

MS. HUGHES: Right. But I just -- yeah, I just don't -- don't sweat it, we're just trying to make sure that we don't have the big boo-boos of somebody really conducting business and taking votes via e-mail.

MS. FRANCIS: Sure.

MS. HUGHES: Because that is definitely a no-no, you can't take votes via e-mail.

MS. FRANCIS: Okay.

MR. BETZ: I guess one question I have, is there a way, and I guess you can ask legal counsel, in terms of if we copy you or copy somebody else at DMS, if there is anything that would be -- like even the agenda e-mails, we copy you and then you could -- DMS could then put that,

if there's like any type of forum on the website or --

MS. HUGHES: Right.

MR. BETZ: -- anything else that could go out, and then there's no --

MS. HUGHES: Right.

MR. BETZ: -- it's completely transparent. I don't know, you can ask, I'm not sure if that would --

MS. HUGHES: Yeah. I don't think we want to put necessarily the e-mails and stuff out there. But if you-all -- like, for instance, when you sent me the -- sent out the information yesterday and you had the minutes, which I always put the minutes out there anyway. Now that you voted and approved the minutes from July, they'll go out this afternoon, you know. All the different things, we can put those out on the website and not be a problem there. But I think -- I don't think this TAC is actually doing anything that creates a problem.

My only big question is -- because I e-mail you-all all the time, you know. Now, mostly what I e-mail you is not necessarily conducting, just other than, you know --

MS. FRANCIS: Communication.

MS. HUGHES: Right, it's communication. So, I don't want -- I don't want that to stop just because we have an Open Meetings Law. But I'd like to have an attorney tell me not to stop. So, you know, we just put that together kind of as a down and dirty of what you can and can't do.

MS. FRANCIS: Well, I can see that we are -- we as the Pharmacy TAC are very judicious as to what we bring as official recommendations to the MAC. But I could see where other TACs might just say somebody recommend something, then they bring that to the MAC. I don't believe we've ever done that.

MS. HUGHES: Right. I've not seen anything that makes me think that you-all have done anything in this year that I've been doing it, you know, so I think you-all are fine.

MS. FRANCIS: Okay.

MS. HUGHES: I just need to find out about the e-mails and I will let you know about that.

MS. FRANCIS: That's a good reminder, alert for us.

MS. HUGHES: Right.

MS. FRANCIS: Okay. Is there anything

else from DMS?

MR. JOSEPH: I'm just going to add the 340B policy. I think I sent this out to Mark. We're pushing the implementation to 1-1-20. So if you are a contract pharmacy, then starting 1-1-20 the way that the state will be excluding those claims from rebate collection will be with the submission clarification code of 20. So those need to be on those claims starting 1-1-20.

MS. FRANCIS: So this was the item I had as under new business.

MR. JOSEPH: Okay.

MS. FRANCIS: Why don't we go ahead and talk about it now.

MR. JOSEPH: Sure.

MS. FRANCIS: So, 340B.

MR. JOSEPH: Sure.

MS. FRANCIS: I know that there's a lot of dialogue and conversation. It was really brought up at the Hospital TAC meeting in August. And those minutes weren't available yet, but we can go back and read them when they are. But basically -- so, I work at a health system. I just wanted to share, and especially for Jessin and the Commissioner to note how 340B impacts us.

So at St. Elizabeth I run a pharmacy disease management clinic. And every GI provider that has a patient diagnosed with hepatitis C is referred to our clinic for pharmacist evaluation and management.

The pharmacist decides which medication that they're going to prescribe through a collaborative care agreement for the patient, they -- based on their fibrosis level, their drug interactions, things like that. They see the patient back in four weeks, get their levels, and then they make sure that they get back to the provider in twelve weeks or at the end of therapy. And they make sure that they have their twelve-week post-therapy lab. So far we have a hundred percent hep C cure rate at our clinic.

To me, 80 percent of our population that's referred to us is Medicaid. So, we do not carve in Medicaid and 340B yet, but we're looking at it. We also have a ton of payer lockout. We do the same process. We complete the prior authorization, we see the patients back; even if we're not filling the drug, we still do that. We can only afford those clinical pharmacists to do that through 340B.

And so I think because we have so much payer lockout, CVS Caremark, whoever else might be, where the network preferred specialty pharmacy is not able to be filled at St. Elizabeth, if we relied on the contract pharmacies to have to submit those modifiers, I feel that 340B, as we go to carve in Medicaid, is not going to allow us to expand our program to see all of the patients we need to do.

MR. JOSEPH: So do you -- you say you already carve in or you carve out?

MS. FRANCIS: We carve out right now, but we are going to carve in.

MR. JOSEPH: Okay. So, we're giving you the option to carve in.

MS. FRANCIS: Yeah.

MR. JOSEPH: That's all we're doing.

MS. FRANCIS: But the contract pharmacy part is the hard part, because it's kind of like we're -- is CVS Caremark, or Avella, or Briova, or whoever it is going to be able to comply with the technology of that modifier.

MR. JOSEPH: Right, I understand that, but that's a decision that the covered entity has to make with the specialty pharmacy.

MS. FRANCIS: Is there not one that the manufacturers could help?

MR. JOSEPH: No. We've tried, we've tried the manufacturer.

MS. FRANCIS: Just like any other rebate program.

MR. JOSEPH: No. So, we collect those rebates from any pharmacy right now. If you're a 340B eligible pharmacy at the 340B covered entity, then we won't collect the rebate. But if it's at a contract pharmacy we will collect the rebate.

What we're doing with this new policy is we're, basically, opening the door for contract pharmacies. And I understand the technological considerations that have to be made, but if those can be met, we don't have an issue with it. Yeah, that's pretty much --

MS. FRANCIS: Have we talked to, just for my knowledge, other states? Are they implementing this modifier where contract pharmacies already have the technology to do it?

MR. JOSEPH: So about 20 -- yeah, so we've done -- we've done the research on this. So, it's about 24 states use the claim level identification process, so putting the modifier on there.

Twenty-four states use the -- what's called the provider level exclusion, so what we currently use in Kentucky, and disallowing all contract pharmacies. And then there's a few states that use this retrospective identification process. So, basically, allowing the 340B hospitals to use contract pharmacies, but then at the back end reach out to the rebate vendor and collect the rebate -- or ensure that we don't collect the rebate on our end.

We tried to go that back end route, the route that a few states have done, but it's been a challenge both on our rebate vendor side, that's never done it before, and then what we would need to do here at the state. So because this solution already exists, and we can still allow contract pharmacies, we decided to go with the claim level identification process.

Again, I hear the concerns around the technology portion of it, but the company that fixes that is probably going to make a billion dollars. That's just the honest truth. I don't know any other way, besides us building that retrospective model, to really adhere to the concerns of the covered entities right now. I

think the biggest holdup is the technology portion of it.

I would say that the other part that I see is if you're a rural hospital, and you use 340B and you want to use a contract pharmacy, then independent pharmacists who have an independent pharmacy typically know the community, typically know the providers that are working at that hospital, and can identify one way or another either through -- again, it has to be smaller communities, but either through a chart or something on -- at the desk about which providers provide services at this 340B hospital. So when a prescription does come in, either they can identify it on the prescription itself and say this is a 340B patient, so run it through your 340B stock, that's one solution, but I think that's -- I'm reaching at that one, but yeah.

MR. CARRICO: I guess I'm confused on what's the problem with the technology part. Because, I mean, I know certain contracts require you to submit this 20 on the SEC already, so what -- what's the change that's going to be the difficult part?

MS. FRANCIS: So for the contract

pharmacies to do it on behalf of us, to make it 340B eligible, that it's going through 340B stock.

MR. CARRICO: Oh, so they don't know currently if -- got you.

MS. GRAY: It's relying on the pharmacist at the point of sale to know whether it's eligible or not.

MR. PALUTIS: Why wouldn't -- why wouldn't as the covered entity, why wouldn't you have your TPA scrub the data anyway. And if there's something that got missed, you could always go back and edit the claim and put that qualifier on there. I mean, they make their administrative fee, let them do their job. I mean, I'm unsure -- I hear your concern, I'm wondering what your concern is, but I'm not -- I agree with Matt, I don't really see -- the technology is there, it's really easy. If it's a 340B claim, you throw a 20 in there and you go about your day.

MR. VENNARI: But how does the TPA identify it if they go back and scrub it?

MR. JOSEPH: Yeah, they wouldn't know till the claim is processed. The TPA doesn't get that data.

MR. PALUTIS: Well, I understand, but I'm

talking about after the fact.

MR. JOSEPH: Oh.

MR. PALUTIS: So, I don't know how often the TPA goes and scrubs the data, but if they scrub the data, and they see the provider, and they see the patient, and they see the drug, but they -- you know, they could go back and -- I don't know, this might be more work for the TPA.

MR. VENNARI: But the presumption is that that one provider only writes 340B.

MS. FRANCIS: That's exactly it.

MR. JOSEPH: Yeah, that's another assumption.

MR. VENNARI: So, I mean, you can't do that, because they might not see just 340B patients.

MS. FRANCIS: Our providers are only eligible when they're in the hospital, not when they're in clinic.

MR. PALUTIS: And so the TPA wouldn't have that data that links the patient, and the prescriber and the drug.

MR. CARRICO: Well, I'll say one thing that I do in my store. We don't have a TPA. So like we do our part, the entity does their part,

and we kind of make sure everyone's doing everything. Like on Mondays I'll run a report for all 340B drugs dispensed. I run one for Humana, because you have to submit Humana. And I run it and I check all dual eligible and Medicare patients. And techs go back and make sure everything got submitted with the 20.

And as far as ones that -- physicians that work in two different places, like a hospital and a clinic, we end up making -- I don't know how everybody's system is, but Rx30, I've just made two profiles for one physician. And you can say this profile is 340B eligible, this one's not. You say this one will be hospital profile, this one's not. And the system will block you from using 340B on the non-340B profile.

MS. FRANCIS: So, we do that within our own pharmacy. But with contract pharmacies, I think there's the question of will they go through that type of legalese. And I honestly don't know -- I probably am not the expert to talk about the technology portion of it. But I know that KSHP is probably going to submit something on behalf of this same topic.

MR. JOSEPH: What's KSHP?

MS. FRANCIS: Oh, the Kentucky Society of Health Systems.

MR. JOSEPH: Okay, sure.

MR. CARRICO: It's cumbersome, but so is 340B in general.

MS. FRANCIS: But, Jessin, if you do have examples of how this same process is done in other states, and I'm sure you have exhausted those, but maybe that would help as to how to speak with their current contract pharmacies.

MR. JOSEPH: Yeah, I mean, in terms of how other states do it, we just -- honestly, DMS needs a policy in place. So, DMS has not had one in place since managed care's entered the market and since 340B has expanded significantly. And so -- and then, you know, once we started we were quickly aware of the number of contract pharmacies using 340B drugs for Medicaid patients, which is in violation.

So if a drug manufacturer comes to the state and they say, hey, we gave a 340B discount and then we provided the state a rebate. Because the state does not have a policy in place, we are the ones liable for that. So because we know what we're doing, what we said is this is what we do,

this is what we'd like to move towards, and it makes sense for the inclusion of contract pharmacies moving forward. That's why the proposed policy came out.

The proposed policy is still the proposed policy. It has up until -- I think October 3rd is when we're going to close feedback submission. So, we've already received a handful, that's part of the reason why we're extending this. But, you know, at the end of the day the state just needs to protect its rebate. And then to ensure that everybody else at least knows what we're doing, so nobody's really culpable at the end of the day as long as everyone's following the same rules.

MS. FRANCIS: Okay. Cindy, did you have anything else?

MS. GRAY: You're still using Magellan, right?

MR. JOSEPH: Uh-huh.

MS. GRAY: Are they not addressing this at all with anybody? I mean, they're going to have to at some point.

MR. JOSEPH: They do. So, they -- they do. They're the rebate vendor for, I think, about 16 states. But the claim of identification for

them is the way that they recommended to us. We asked them to look into that retrospective model. The only retrospective model is Oregon. Hawaii tried it, but you'll find an OIG report out there that says that Hawaii kind of fumbled it at the end of the day. And then -- so, we tried, we had Magellan, actually our Magellan team, reach out to Oregon's DSC team to see if we could do it on their end. It essentially came back to the point that they have to build it for the first time and they've never done it before.

And, you know, I wouldn't be surprised at the fact that the contract ends in a little -- in about what, 14 months. It would take them a year to build it, and we would only be able to use it for however many months after that until the new PMRP comes out. And so I'm not surprised that, you know, they gave us some facts around the fact that it's hard to implement, it will take so much time to do. But I don't know, you know, that could just be speculation on my part.

MS. GRAY: Yeah, they need to go on and start it. They're going to have to do it at some point. So if you never start it, you're never going to get there.

MR. JOSEPH: Right, but we would also have to pay for it, and because this -- the system already exists where we can just ask for the claim of identification. And the Commissioner is onboard. The Commissioner has actually stated that if we move to this retrospective model, we expect the covered entities to pay for the new model. And then we are going to require that any rebate missed at a contract pharmacy is paid back to the state.

MR. PALUTIS: Paid back to the state by the covered entity?

MR. JOSEPH: By the covered entity.

MS. FRANCIS: So if a PBM -- or I mean a contract pharmacy is required to build in this technology, likely those fees are going to be passed on to the covered entity I would say.

MR. JOSEPH: Yeah, that's up to the contract.

MS. FRANCIS: So --

MR. PALUTIS: The technology is already there. I mean, every pharmacy -- I would be willing to bet every pharmacy system that exists has the technology already to just submit the code, right. The question is, is are they going

to submit the code when it's appropriate to submit the code. And that's what -- the hospital system, you're afraid you're going to miss out on your 340B product if Matt's contract pharmacy doesn't put the code in, the state gets the rebate and not the hospital system, and that's where the concern is, right --

MS. FRANCIS: Yeah.

MR. PALUTIS: -- I'm guessing.

MS. FRANCIS: Yeah, just the data collection involved.

MR. PALUTIS: Right.

MS. GRAY: And my concern around that is whether the pharmacist at the point of sale is even going to know if it's eligible or not. And if they do, will they remember to put the code in. So then that causes an issue, too. I think that puts an undue burden on that pharmacist, but that's just my opinion.

MR. PALUTIS: I agree with all of your points, I do. But I also think that there's so much money involved with 340B and the ability to bill for Medicaid to provide these services that you're talking about, that if the covered entity has to work in conjunction with the -- with the

contracted pharmacy to either come up with something like Jessin suggested, whether it's a notation on a script or a hard copy, and maybe for 340B the covered entity says you have to do a written prescription, or you can do it electronically and just note it a certain way, to me, in my opinion, that's a small price to pay in order to have access to those rebates, whereas in years past we didn't have access to those.

MS. GRAY: Absolutely.

MS. FRANCIS: Yeah, I am grateful for that. So that works.

Jessin, thank you for being patient with us as we work through that.

MR. JOSEPH: Yeah, no problem.

MS. FRANCIS: Okay. So, MCOs, any updates? I guess we'll start with Joe from CareSource.

MR. VENNARI: Really, the major update I have has just been working with Humana as they internalize the operations the past few months. So, we've been doing a lot of building, working out the benefit internally with Humana, working with folks over there and testing it, so it's -- that work is proceeding very well. That's the

majority of what --

MS. FRANCIS: For the January 1st?

MR. VENNARI: January 1st, yeah.

MS. FRANCIS: Is there anything that you know of yet that pharmacies are going to notice right away?

MR. VENNARI: Well, they should get recarded.

MS. FRANCIS: Okay.

MR. VENNARI: So, you'll see that, see recarding. There will be notifications that will be going out to the members and providers, like through those letters about a week or so ago.

MS. FRANCIS: Everybody will have new ID numbers and things. Do you know when those are going to be sent out? Will they have them before January 1st?

MR. VENNARI: They'll be going out -- yeah, they have to go out 30 days in advance. But I think the target is, we were discussing this a little bit, we're looking maybe at possibly November 1st. They don't want to go too early, they don't want them to forget about it, so we've been playing around with that. Probably around the middle of November is where we'll settle out.

MS. FRANCIS: Okay. So, April, Aetna.

MS. COX: From CPESN, so our first touch on the expansion, we haven't completed the expansion process yet. We keep pushing the go op date back. And that's just because after doing the initial pilot with the western Kentucky pharmacies we identified some vendor issues with specific vendors when they submit the care plans. So for our second round for the pharmacies we're looking at for northern Kentucky, we're actually having them submit sample care plans ahead of time to make sure that they -- their vendor can provide the information that's necessary for a complete care plan. Because we have encountered issues in western Kentucky, so we're trying to prevent that from any new pharmacy we allow in the program.

I know they were discussing this on Friday, but I've been out for the past few days. So, I don't know if they set a new go op date, because I've been out. But I wouldn't expect it before October 1st. But, again, it just depends on how quickly they get the sample care plans in and we approve them. Because once we approve them, then at that point it will be a pretty simple process.

Outcomes data, our clinical pharmacist out of corporate will be handling the outcomes for CPESN. She actually just did a presentation internally discussing what they're looking at and the ideas they have on how to report the outcomes. She's looking at January through May, I want to say, April or May for her initial data pool. So, she just received that data, so it's being analyzed currently. So, I would say I would have that for you at the next PTAC, but I will be in Phoenix for a work meeting in November. But I will definitely have outcomes data the next time I'm here, because she's analyzing the first quarter or quarter and a half, however she's doing it, for the pool. So that will be available.

There will always be, I think she said maybe up to like a six-month lag time in between, you know, the data and the outcomes, but they -- they are definitely looking at that now and have some really good ideas of how they want to pull that in from a clinical outcomes perspective. So more to come on that.

And I have not seen the latest satisfaction data report. Again, that may have come out Friday in my absence. So once I have

that, I can let you guys know that as well. Other than that, everything else has been pretty quiet at Aetna. Just been focusing on trying to expand this program. We've got a lot of people that are interested in buying in. It's been really successful for us so far. So, I'm just ready to onboard the pharmacies in northern Kentucky so we can move forward.

MS. FRANCIS: So, you still have 15 additional pharmacies to roll out?

MS. COX: That we're looking at.

MS. FRANCIS: Okay.

MS. COX: But if they cannot submit the care plans in the format we need, they will not be able to join. And that --

MS. FRANCIS: But those are all over the state, not just one --

MS. COX: Right, they're all over the state, but we're looking specifically right now in northern Kentucky. So, we started in western and now we're looking in northern. And, of course, the plan, the goal is to have pharmacies throughout the state that are in our network for Aetna for CPESN. But, you know, we're just trying to do it in small increments at a time. So,

basically, we're just waiting to see if all of these pharmacies can actually submit the data and information we need and the care plans to be complete.

And so we have a case manager that's dedicated to this program. And she's the one that reviews the care plans. And what we've just found, it appears to be more of a vendor issue than a pharmacy issue, where there's no field for the information to be submitted. And it's information we need to be able to --

MS. FRANCIS: Sure.

MS. COX: -- you know, to put it in our own system. So that's been the only holdup is just getting them to submit those care plans so we can get them onboarded.

MR. GLASPER: April, is the program far enough along and are the pharmacies -- would we be able, KPhA be able to get some information about the program and about the participants --

MS. COX: Sure

MR. GLASPER: -- to see if they're KPhA members, and we could certainly do a story about it in our magazine.

MS. COX: Absolutely. Let me talk to Ted,

my director, I'm sure you probably know Ted Cummins, and see what we can pull together for you.

MR. GLASPER: Okay, great. Thank you.

MS. COX: Uh-huh.

MS. FRANCIS: WellCare.

MS. ROGERS: No significant updates really. We did, and I know this is later on the agenda, we did add the Permethrin 1 percent. I think that was brought up at the last meeting, so that's added.

MR. CARRICO: Thank you.

MS. ROGERS: No, thank you for bringing that up, so that's done. And then we are looking at some opioid edits, just more safety edits. And so I will be sure that there's communication before those go out. And that's it.

MS. FRANCIS: Did any other MCOs add Spinosad to their formulary?

MS. ARMSTRONG: We had it on formulary, but -- it's been on formulary, it's still there.

MS. FRANCIS: Okay, so WellCare and Passport.

MS. ROGERS: Let me clarify. We didn't add the Spinosad, we changed the trial

requirement. So, it was Permethrin 5 percent, but that was not the most appropriate trial, and so we changed it to the 1 percent.

MS. COX: And we have it as well with a step, but that -- it was already set up that way, with a step.

MS. FRANCIS: Because that was the issue is you couldn't get Nix, right?

MR. CARRICO: The generic was unavailable for a while; and the ones that were, weren't covered. But I ran a claim last week, and I forget which MCO, but it was covered, so I didn't know there was a change.

MS. ROGERS: Okay. If you have any issues for WellCare, just let me know.

MR. CARRICO: Will do. Thank you.

MS. ROGERS: Okay.

MS. COX: So are you saying the supply issues have resolved for the Permethrin 1 percent? For like a week I was getting all types of calls, and I haven't heard anything in like over a month.

MR. CARRICO: I'm not sure it's resolved. I've only been able to find one product available. Permethrin wasn't covered before, but it is now. But I don't know if it's resolved across the

board, I just know at ABC, they have some in now.

MS. COX: Okay.

MS. FRANCIS: I'm sure it depends on your wholesaler. And if the NBC's in the system, but --

MR. CARRICO: Right.

MS. COX: And I guess the next issue would be whether or not CMS is rebate eligible.

MR. CARRICO: Correct.

MS. COX: Which is what, I think, a lot of the issues were. Because most of the ones, I know from what I found, that we covered were CMS rebate eligible, but they, apparently, weren't available to be ordered.

MS. FRANCIS: All right. Anthem.

MR. RUDD: The only update for Anthem is we are still set to go live with Rx on October 1st. So, we're still waiting on the status of the MAC list approval, I think is the one outlying piece for implementation. As far as processing, the new BIN PCN has been out for a while, so they're -- they process parallel with the existing ESI BIN PCN, as well as our Rx BIN PCN, so either one will work.

The ESI BIN PCN will cease to work after a

period of time, but there's enough -- should be enough transition that there shouldn't be any issue processing claims for that.

MS. FRANCIS: Are there adjudication edits that refer to the new BIN PCN?

MR. RUDD: Yes.

MR. JOSEPH: We place all the BINs PCNs on our website as well, on our pharmacy web page. The pharmacy web page has all the BINs and PCNs. And we've added the two for Anthem right now.

MS. FRANCIS: Okay, for all the Anthem.

MR. JOSEPH: Yeah. We'll add the Humana once they get them.

MS. FRANCIS: Okay, okay.

MR. RUDD: Yeah, I think I gave you both, so you should --

MR. JOSEPH: Yeah.

MS. FRANCIS: All right. Passport.

MS. ARMSTRONG: No major updates, but we are getting ready to fax blast out our third quarter newsletter that has all the different changes that were made at the last PAT. And, also, we made a few changes to prenatals, and so there's a list of all the NDCs that we do cover in the newsletter as well.

MS. FRANCIS: Okay. If we have a newsletter like that, Mark, can you send it back out as an e-mail blast?

MR. GLASPER: Sure.

MS. FRANCIS: All right. So anything from the PTAC committee on current states or --

MS. MILLER: I just wanted to ask of the MCOs, do you know if your PBMs allow auto shipment of medicine to the members, like if they can get shipments of medication without asking for it?

MS. ROGERS: From Medicaid?

MS. MILLER: You're not allowed, okay.

MS. ROGERS: From Medicaid?

MS. MILLER: Yeah, yeah, a Medicaid recipient.

MS. FRANCIS: Okay. So, I had that under new the business, because -- no, you brought that up to me initially.

MS. MILLER: Yeah.

MS. FRANCIS: Paula said that she was doing a med review for a patient that had been taking Prilosec -- or shipped -- has been shipped Prilosec, but she was potentially asking them about stepping down to Zantac. And so he said he doesn't take something for GERD all the time and

he said they just auto ship it through the mail to me. And so she was like -- you know, we know that MSD this can happen. And I do sometimes, but I can't say that it's Medicaid at all. I get physicians that are like can you call this mail order pharmacy, because something was $800 and they -- it's in their fine print to just ship it when it's ordered, even though it's not covered, or they won't do coupons or whatever.

Now, I'm sure that's not Medicaid with the coupons, but sometimes there are some funny things with the mail order, you know, that are auto shipped and I think it could be a source of waste.

MR. VENNARI: Do you have an example of anything?

MS. MILLER: Well, that was the example I came across. But for all -- I mean, the patient could have given permission. It just was the way he said it to me, it just made me wonder if that was an allowed thing, that it's auto shipped. I mean, I can look for more specifics, but it just --

MR. VENNARI: You don't remember where?

MR. CARRICO: Yeah, was it from CVS Caremark or from --

MS. MILLER: I'd have to look. I could go back on the MGM and check.

MR. CARRICO: I would -- I would check. But then, also, we've checked our systems and no one's done this, but I know other states are having this problem where PillPack has been taking data from CVS Caremark and then blindly shipping to patients. So, I know that we're good on our end, so -- but other states do have that issue. I think Ohio had that before, too, so that's just a head's up.

MR. VENNARI: I haven't heard of that, but if you do find anything --

MR. CARRICO: Yeah, they take some subsidiary's data --

MR. PALUTIS: There should be a lawsuit, they're going to kill somebody.

MR. CARRICO: Yeah.

MS. FRANCIS: How in the world.

MR. PALUTIS: I don't know how they sleep at night.

MS. FRANCIS: All right. Just to be aware, because it seems like we do get -- and it may just be a point of, you know, the pharmacist, the things are on -- I mean, the patient's things

are on auto refill and the patient doesn't know what things are for and stuff, and Paula caught that in the midst of doing the review, but -- so definitely don't want to waste it if we don't need it.

MR. VENNARI: Was that from -- do you know, did it come from mail?

MS. MILLER: Yes.

MR. VENNARI: Are you sure it came from mail and not a local pharmacy? Because a lot of times local pharmacies will auto do something and then call you and say it's ready.

MS. MILLER: Right, they had stuff like that.

MR. VENNARI: Was it a 30-day supply or 90-day supply?

MS. MILLER: Well, I thought he said 30.

MR. VENNARI: Because we don't allow -- mail is typically 90. So that's why I'm thinking it might not -- it might be like a local chain or something like that that's doing it.

MS. MILLER: He said it was shipped through the mail, but, again, you know, this is one guy telling me.

MR. VENNARI: Yeah, I mean, I would

definitely find the source of that.

MS. MILLER: Yeah, yeah. I'll see if I can find out.

MS. COX: Was he a dual, did he have Medicare?

MS. MILLER: No.

MS. COX: Okay.

MS. FRANCIS: So to your knowledge no Medicaid has auto shipped through mail?

MS. COX: We don't generally allow mail. It's like an exception. It's like a dire need to get mail.

MR. VENNARI: Yeah.

MS. MILLER: Okay.

MS. FRANCIS: Okay. All right. So just following up a few things quickly on previous agenda items I just wanted to close the loop on. First of all, Jessin, thank you so much for your follow through with the vaccine chart. That has been used a lot from pharmacists in my network of pharmacists and they were appreciative of that. So, I think that's something that if there are any immunization coverage changes at all, I'd ask that maybe we just bring it to PTAC or to Jessin so he can update that chart and we can send it out.

MR. JOSEPH: Sure.

MS. FRANCIS: So that has been completed. The other thing that was completed is on the KyHealth website, the MCO pharmacy ID numbers are listed and so that was completed.

MR. JOSEPH: Can I ask, are pharmacists now reporting to the immunization registry?

MS. FRANCIS: Yes, I was going to give that update here. So, I wish it was just that easy to say, yes, pharmacies are reporting to the immunization registry.

MR. JOSEPH: Okay.

MS. FRANCIS: But it's a process that I'm working on.

MR. JOSEPH: Okay.

MS. FRANCIS: So, I think at the last meeting I told you I was getting ready to have a meeting on the immunization workgroup that I'm on to encourage pharmacist reporting. So right now what we're doing is getting a list of all pharmacies that do report and all pharmacies that are like registered in the State of Kentucky as pharmacies, so we can see who is not reporting and then filter that down as to the reasons why.

MR. JOSEPH: Okay.

MS. FRANCIS: So, we had the survey, a lot of it's lack of knowledge. Some of it was because of vendor systems and charges and things like that. But we'd like to, really, just work through that. Now that KHIE has gone live with their new updated system in mid August, I got that information from Andrew Bledsoe at KHIE, and then also working with the registry, and I'll keep you updated, but there's a lot of efforts going on with that.

MR. JOSEPH: So let me just ask. Immunization's primarily being pushed by DPH just with -- in association with us, so we're pretty much hand in hand on what we're doing. If DPH were to mandate that the immunization registry be used, what is the pushback that we can expect to have, or will there be pushback?

MR. CARRICO: There'll be pushback.

MS. FRANCIS: I think the pushback would be is to make sure -- there would need to be time for electronic upgrades or whatever needs to happen for HL7 data to be submitted to KHIE for KHIE requirements.

MR. JOSEPH: Okay.

MS. FRANCIS: There would also need to be

realization that a lot of the vendors, not KHIE, but the pharmacist vendors charge -- charge like a monthly fee for that. So, it's more dual hardship on the pharmacies that are already under-reimbursed and having a hard time at this state of affairs. So, I think there's that realization. I think it's also just educating and how -- how to set this up. So how do we go through the state and work to educate everyone from the chains to -- I think chains would figure it out. I think it would be harder for the independents and things like that with all of the different vendor systems.

MR. JOSEPH: Would a manual upload be --

MS. FRANCIS: It would be impossible. With flu shots and things like that, I feel like it would be really hard. There's no way there's labor in the pharmacy to do that right now.

MR. CARRICO: What I don't get, and maybe I'm overlooking this one charge, but I know I was one of the first five to sign up for it with KHIE and then I stopped after it just got to be too much. Because they would charge you a monthly fee, and then if you wanted to put past ones in it was like 75 cents a script if you wanted to

manually load, if it was stuff that happened beforehand.

But, Chris, maybe you know, do we pay to submit stuff to KASPER?

MR. JOSEPH: No.

MR. CARRICO: So why can't this be like KASPER?

MS. FRANCIS: So, it was my knowledge if we went directly to Kentucky Immunization Registry there would not be these charges and issues that we're having with pharmacies. But because the -- I don't know if it's a statute, but because the workflow is that you have to go through KHIE first for the data exchange, that's where the HL7 and whatever information that's needed to talk between the vendor systems, that's where it's become hard for the pharmacies.

MR. JOSEPH: Okay.

MS. MILLER: So the charge is from KHIE?

MS. FRANCIS: The charge is from like say Ruwe Pharmacy's vendor, pharmacy operating system vendor, to get it compliant to be able to upload to KHIE.

MS. MILLER: Got you, okay.

MS. FRANCIS: KHIE doesn't charge. But if

we were reporting directly to the Kentucky Immunization Registry, it doesn't require some of the electronic needs that KHIE would require.

MR. JOSEPH: But that would be manual, though, right?

MR. PALUTIS: No matter what happens -- I mean, there's not a charge on our monthly statement for KASPER, but I'll guarantee you we pay, because the software vendor had to make the system work so it talks to KASPER. If you mandate something in Kentucky, pharmacies will pay more money. It may not be a line item that says immunization registry, but everybody's maintenance fees will go up if the vendor has to provide some sort of platform to transmit this information.

MS. FRANCIS: And do I think it's good for -- I absolutely think it's good for patient care, and, of course that's what I'm advocating for. I think we just need to consider that, in it, ultimately, usually ends up coming back on the pharmacist, so --

MR. VENNARI: What's the charge per click?

MS. MILLER: Between 35 and 85 just depending on per month. It's not --

MR. VENNARI: $35 and $85 --

MS. MILLER: Yeah.

MR. VENNARI: -- or cents per click?

MS. MILLER: Per month. You have to buy a subscription to -- you know, it's an extra fee.

MR. CARRICO: So even if you don't use it, you're still paying it.

MS. MILLER: Right.

MR. VENNARI: Right. Why is there such a -- why is there a $50 range?

MS. MILLER: It's really complicated, but it's like who you're working with. From my pharmacy, we had to pay 85 a month, because I also have to pay a doctor to sign the thing and it's like this whole convoluted mess.

MS. FRANCIS: That's the other thing, it's getting really hard to find physicians, I actually was going to work on that, it's getting hard to find physicians to sign protocols.

MR. JOSEPH: Isn't Prescribed Wellness a company that identifies --

MS. MILLER: That's who I pay.

MR. JOSEPH: Yeah. So, they're charging 85?

MS. MILLER: Yeah.

MR. JOSEPH: Okay.

MS. MILLER: But then also to get the data to KHIE, I give the vaccine today, then I have to go in the next day into their system, add information. So, I have to do like dual entry on every --

MR. JOSEPH: Right.

MS. MILLER: And once I give it to Prescribed Wellness, then they will upload it. Although, I've paid for it for a year and not one thing has gone up, so --

MS. ROGERS: Susie, I just want to go back to your comment. You just said you're finding it difficult to have physicians sign off?

MS. FRANCIS: Yeah. So, again, I don't, because I -- well, even within my own health system there's always the worry from physicians, but it's a little bit easier for me. But for independent pharmacies, I continually get people that reach out to say their immunization protocol needs to be resigned by a practitioner and it's not -- they're looking for one.

Now, I know a local, a chain pharmacy actually, in northern Kentucky that has their protocol signed by a pain management doctor. To me that doesn't sound exactly appropriate for

immunizations. Why do we not have, you know, physicians that can do this.

Now, Shannon Stigwood said that she might have some contacts. When I initially brought this up probably a year or so ago with some immunizations coalitions, they said that they didn't feel like there was a problem through the pharmacy networking, but, I mean, I can just tell, Paula's had issues.

I don't know, Matt, you might have a better relationship with some independent practitioners there, but --

MR. CARRICO: I just deal with one. So once he's retired I don't know what I'm going to do.

MS. FRANCIS: Yeah. Even Kroger, when I was with Kroger, had a hard time finding -- they ended up having to work around with The Little Clinic to do it, but --

MR. JOSEPH: Isn't that what Prescribed Wellness is advertising, though, the fact that they can --

MS. MILLER: They do, right. So, they -- you know, you're paying that fee for a doctor to sign, who you don't know.

MR. JOSEPH: Right.

MR. PALUTIS: Yeah, you pay them $20 a month. But they also give you -- you have, it's like a 180-page document where you can pretty much give any kind of vaccination, I mean, the protocol's in there. So if you want to do vaccinations --

MR. CARRICO: But I thought you weren't allowed to pay physicians to sign off on that.

MR. PALUTIS: You're not paying a physician, you're paying Prescribed Wellness.

MS. ROGERS: They're paying a physician?

MR. PALUTIS: I'm sure they are. And the physician changes every so often, so they send out a new updated protocol.

MS. ROGERS: I guess I'm just struggling, why is this an issue, why won't physicians sign off on the protocol?

MR. CARRICO: I don't think they want the liability.

MS. ROGERS: Don't want the liability, okay.

MR. CARRICO: The guy I use is a county away, so I know I'm not going to be taking any of his patients.

MS. ROGERS: Got you.

MR. CARRICO: But I'm guessing liability.

MR. PALUTIS: Before Prescribed Wellness I had to convince a neighbor of mine who was an ER doctor to sign mine. I mean, I couldn't get a doctor within five miles of my pharmacy to sign it.

MS. FRANCIS: I have a private ID physician sign mine that has no affiliation with St. Elizabeth, because they don't want St. Elizabeth physicians, it's a corporate thing, to go through that. But then I found out that he is only licensed for adults, so that doesn't help us with age 9 to 18, so I had to redo that. So, it's really a public health need I think.

Pharmacies should not be paying physicians for this when we're increasing access. And I actually -- St. Elizabeth physicians, they refer all of their adults on Medicaid to me for immunizations, so --

MS. ROGERS: Well, that's interesting.

MR. VENNARI: They pushed away a lot of the vaccines to pharmacies, because they don't want to stock it and the cost, but now they want a cut. But now they still want a cut, a piece of

the action it sounds like.

MR. PALUTIS: Well, what they do, if we take all the -- if you add up all the pharmacies and all the immunizations we give over the course of a year, I bet you collectively there's money lost, right, because of vaccine's expired, you can't send it back, right, and you just eat -- and you have to have the vaccine or else you can't give it. I mean, it's a big thing.

MR. VENNARI: Well, then they should go back to having --

MS. FRANCIS: Oh, temperature monitoring, all that.

MR. PALUTIS: Yeah.

MS. MILLER: Jessin, from a public -- the public health is very interested in immunizations. Is there anything that they can do to help support the issues?

MR. JOSEPH: Yeah. So, I think the next thing I was going to ask, would it be helpful if DPH got a physician, so just like Dr. White or standing orders --

MR. CARRICO: Yes.

MS. FRANCIS: Yeah, very much. I reached out to Kentucky Health Department, and Dr. Sadler

was like I -- she's not allowed to sign anything, so I --

MR. JOSEPH: Oh, really.

MR. CARRICO: I was told nurse practitioners aren't allowed to sign off on those either, is that true?

MS. FRANCIS: They are allowed as practitioners.

MR. JOSEPH: Yeah, I think Dr. White would be more than happy to do it, I'm just wondering --

MS. FRANCIS: She's leading the provider immunizations.

MR. JOSEPH: Okay. Yeah, if you want to bring it up to her, or I can bring it up to her and see how she feels about it.

MS. FRANCIS: And, I mean, if -- honestly, if it's -- even if we had just a Board of Pharmacy approved immunization protocol that Dr. White also was comfortable with, and then she could sign for all pharmacies in the state. It's just -- so some pharmacies are just like I'm not dealing with that, because I'm not going to go through --

MR. JOSEPH: Yeah, yeah, understood.

MS. FRANCIS: But so that's -- that would help, I think, saying we're helping -- you know,

we're helping you with your immunization system, and then figuring out -- that's my goal with the immunization workgroup is to figure out what barriers there are to pharmacists reporting to the registry.

MR. JOSEPH: Yeah

MS. FRANCIS: And so.

MR. JOSEPH: Yeah.

MS. FRANCIS: Okay. And then the Commissioner just asked what MCOs are doing to encourage their members to get immunizations. I just know from my standpoint working with the MCOs, I know there are a lot of quality measures that they encourage their members to do. But did you-all want to speak to that, or I don't know if you look back on any response to that question.

MS. ARMSTRONG: We send out member communications to encourage different immunizations. We have all of our representatives in the community that are encouraging it as well at health fairs or the providers. I mean, we have like several different things that we're doing.

MS. COX: We have text campaigns where we reach out. We have one going on now for flu vaccine.

MS. FRANCIS: Okay.

MS. ROGERS: And I would just add, we actually have our care coordinator team, they're actually calling members at those various time points when they're due their immunizations, in addition to the mailings.

MS. FRANCIS: Okay, good. I feel like there is work being done to do that and I appreciate that. And some of it might be education too. I think there's a lot of education around childhood immunizations, and, you know, for infants, and babies, and series up to two years old. But then there might need to be some more targeted education for adolescent immunizations and some for adult immunizations, too. So that could probably also --

MR. PALUTIS: Have any of you thought of doing an adjudication message? I mean, I know there's something that I could go through on my system's end. If I want the service, they'll alert me if someone's ready for the Prevnar 23 vaccine based on whatever their history is and all this stuff. I mean, you-all have access to information, it would be real easy for you to send a message to the pharmacy that says, hey, you just

filled a prescription for Mrs. Jones, you know, according to our records she needs this vaccine.

MS. COX: We do health tag through CVS for certain vaccines. I mean, I can't say that it encompasses all of them. But they do have health tags that will populate on the prescription leaflet, hey, you're due for this or have you had this, you know, I know that they do that. I don't think that it covers all vaccines, but I can find out.

MR. PALUTIS: That's a real easy way to communicate with the pharmacy, you know, so the pharmacy doesn't have to -- you know, whoever's processing the claim doesn't have to pay attention, you know, doesn't have to -- technicians are usually processing the claim. They don't know what people need, but they see the reply. You know, when we get these, we get the claim back, and if there's a message that pops up we could red flag it, it could automatically print or whatever, and then we could have the conversation with the patient to encourage it.

MS. ROGERS: Yeah. That is something that we have explored and we all -- CVS has the health tag program available. But I really like your

idea, and I think there's maybe other preventative measures perhaps that could go along that, you know, get your mammogram, et cetera, since pharmacists are so accessible.

MR. PALUTIS: Right, uh-huh.

MS. FRANCIS: Do all of the MCOs -- are you on the registry, do you get data from the registry?

MS. ROGERS: Yes.

MS. FRANCIS: Okay. So, you would be able to at least pull what is loaded currently on Kentucky Immunization Registry, okay.

MS. ROGERS: Now, me, not personally, but our quality team.

MS. FRANCIS: Yeah. Is there any MCO that is not pulling from the registry?

MR. JOSEPH: So, I think the question is, is the registry good --

MS. FRANCIS: Right.

MR. JOSEPH: -- right. So what's the point of pulling the data if it's not good.

MS. FRANCIS: Well, it definitely needs some work; it can help. I know from experience just in doing the school clinics that I've been doing over the past couple months, I've been

working -- we have a Kenton County school health coordinator, we have the health department on site, and myself with Epic. So between all three systems we're pretty sure of what immunizations gaps there still are. No one system is perfect.

MR. JOSEPH: Right.

MS. FRANCIS: Epic's not perfect, the registry's not perfect and so forth, but still trying to load data in there. And that's only for children because of Epic, you know. A child lived in Ohio up until this year and they bring all the immunization certificates, and the school nurses are combining them all and putting them in the registry.

MR. JOSEPH: Yeah.

MS. FRANCIS: So, I think it's a work in progress, but it's a lot.

MR. JOSEPH: Yeah. So, I would like to figure out what is the source of truth for the immunizations in the state. Because right now all of our data analytics comes off the claim system. At some point I'd like to move to the registry. But if the registry isn't going to get -- if it's not being utilized --

MS. FRANCIS: I think the claims are

probably a better source of truth right now for sure.

MR. JOSEPH: Yeah. And the problem that I have is it's missing a lot still.

MS. FRANCIS: It is.

MR. JOSEPH: Yeah. So, I would like everyone to be onboard with one.

MS. FRANCIS: And even things like flu shots, I'm not even talking about Medicaid, but just like employer flu shots, those a lot of times never get a claim submitted. So, it's not going to registry, it's not going to go to their chart in EPIC or whatever other EMR, so --

MR. JOSEPH: Unless we mandate it. I'm just kidding.

MS. FRANCIS: I'm not opposed to that. But, yeah, there's pros and cons.

Okay. Proration of co-pays. We just had WellCare, Anthem and Humana, they were going to check on those and see if co-pays could be permitted with MedSync. MedSync is required, but there was a question. Passport and Anthem did not currently allow co-pay proration.

MS. ARMSTRONG: For Passport, we've changed that, we've updated it.

MS. FRANCIS: Look at you.

MS. ARMSTRONG: We usually allow for refill too soon overrides to sync those meds. We don't usually get a whole lot of requests for this, but we are making sure that our process includes the proration.

MS. FRANCIS: Okay, okay. So, it can be done. And for those that -- I think personally, it would be a great benefit for adherence, and especially when you can say let me get all of your meds together, I'm only going to give you 10 tablets right now, but next month you can get them all together. And they're like, oh, are you going to charge me two co-pays? But if you can say, no, it's only going to charge for what you're getting, that's a better sell.

Thank you, Carrie, for doing that with Passport.

Any other thing on the follow-ups before I move on to new business?

Okay. DMS quality strategy. At the last meeting I think the Commissioner had said, we were talking about following up for potential pilot programs to determine health outcomes, improvements with the assistance of pharmacies.

And the Commissioner said that that would be looked at after the July, 2020, MCO contracts are outlined. But she said that there is the quality strategy, and that was released for comment on July 31st. And it was on the website, I attached it to the e-mail. And you can comment on it up through September 30th.

Is that correct?

MS. HUGHES: I think so, yes.

MS. FRANCIS: September 30th, okay. And just quickly looking at it, I think there are several areas in that quality strategy that pharmacists could really play an important role and potential -- potential to improve quality in there, especially with the wellness prevention, the chronic disease management, and the substance abuse disorder; so probably each one of the targeted areas in that quality strategy.

But one thing I will say that is a big hindrance is a lot of times these are done only through the provider, and because of the lack of provider status with pharmacists, so -- or some way to compensate pharmacists on these. So whether it's done through MTM codes or -- or what, but I do think that we just need to know, and this

is almost one thing that I would say could be considered for recommendation for the MAC, is to consider that pharmacists could play a big role in this quality strategy.

So comments on that? I don't know if anybody got to look through that. I know it was kind of a big document.

Jessin, do you know of anything going on around the pharmacy end?

MR. JOSEPH: Just around immunizations. So, DPH and Medicaid, and I think the Department of Education is now onboard as well. So just like you reached out to some of your schools, we've highlighted a couple areas -- or a couple counties in Kentucky that have a high number of adolescents that are unvaccinated for any vaccine. And then they also have a low number of VFC providers.

MS. FRANCIS: Okay.

MR. JOSEPH: So, we'd like to set up -- we'd like to reach out to the community pharmacists, and I think we have Joel.

MS. FRANCIS: Joel is working on that with Erica Davis.

MR. JOSEPH: Right.

MS. FRANCIS: I've been on some of those

calls.

MR. JOSEPH: Right.

MS. FRANCIS: Yeah. So, we're trying -- they're trying to work on implementing flu vaccine, trying to track flu vaccine.

MR. JOSEPH: Right

MS. FRANCIS: And then also to improve immunizations across the state, like you said, in low access areas.

MR. JOSEPH: Yeah. And so we'll try to go to nine counties that all have one public school district with high Medicaid populations -- or high adolescent Medicaid populations and try to do onsite pharmacy immunization clinics. My only concern around it is, you know, we can't necessarily close out an immunization clinic for just Medicaid patients.

So in terms of reimbursement, I think Joel and whichever pharmacists are involved, just are going to have to be aware of billing comes after the fact. And so that's why we're looking at the KyHealth.net to see -- make sure that the patients are enrolled in Kentucky Medicaid, and we can appropriately let the pharmacists know whether or not they will be able to bill for the specific

patient. But if it's a private payer, we won't have the ability.

So, we're working to get the logistics out, speaking to parents, getting the information out to the schools, the superintendents, the teachers. And then hopefully, once the pharmacists come in to set it up, you know, all the forms are already completed, all the paperwork is done, it's just book and go and --

MS. FRANCIS: I think I did see, just for your information, the Kenton County superintendent of schools was holding fast to the immunization regulations.

MR. JOSEPH: Yeah.

MS. FRANCIS: They were like they've had over a year to get immunized.

MR. JOSEPH: Yeah.

MS. FRANCIS: So that's where Paula, Russ and I had put together these clinics. I think if you have superintendents like that, saying you need to, that made the parents -- we made them set an appointment and come to us at our pharmacy, and they still, they did that. But it is a large burden on the school nurses to get all the paperwork in order --

MR. JOSEPH: Right.

MS. FRANCIS: -- and see how many more they still have to go. But I will say that it's district by district. Some superintendents are mandating that they're compliant with immunization laws, certificates, and then some are not, so...

MR. JOSEPH: Yeah, yeah. So, we'll hold true and see if we can move forward. I'd like to do it this fall as a pilot. Or I'd like to push for Joel and Erica to get done this fall. But, yeah, we just need to work through the final logistics behind it.

MS. FRANCIS: Sure. Okay. So anything else?

I do think I would encourage everybody to read through that if you can, at least PTAC members to read through that quality strategy document that I sent out. And if there's anything that you think that through the Pharmacy TAC that we could potentially have implications on, to bring it to the next meeting. If there's anything for -- I didn't see anything myself that needed to be commented on before the 9-30 deadline, but if there is, realize that's 9-30, so...

Next, we already covered the mail order

auto ship, there's none that we know of. And then I also attached the Medicaid MCO provider forms just in case anybody was interested in attending those. That information Sharley had sent out to me, so I sent it out to the rest of the TAC. I had 340B, but we covered that.

Does anybody else have new business that we didn't talk about yet?

MR. PALUTIS: Can I tell a -- I've been asked to tell a story.

MS. FRANCIS: Sure.

MR. PALUTIS: A pharmacist who works for me is upset. She has a special needs child that needs care. Now, she's not in the Medicaid system for obvious reasons, but we see a lot of patients who are children that get surgery right around the corner from the pharmacy, so we do -- we make Tetracaine lollipops. And they send over all the post-surgical scripts to our store just because we do the Tetracaine lollipops.

Patient came in, tonsillectomy, Norco Elixir not covered, mom doesn't have money to pay. And it's one MCO that is preventing these Norco Elixirs from being prescribed to the children. And she was just very upset. She called the help

desk; sorry, can't help you, the MCO says they don't want to pay. Call the doctor, the doctor refuses to change the prescription or to do a prior authorization, because they said they tried before and it's been denied. So the doctor just said the patient can either pay for it or not get it. So, of course, the mom doesn't have money, she walks out.

And the pharmacist was just sick, because she'd know that her child needed that medicine at some point, and if he was not able to get it, he would be in a lot of pain. And I'm just throwing that story out there. And the MCO, and I'm not meaning to pick on you, but it's Aetna.

MS. COX: I am very aware of the story.

MR. PALUTIS: Yeah.

MS. COX: And I've talked -- if it's the same case I'm thinking you're speaking of, I did reach out to the pharmacist and I talked to her personally. Now, this may be a different case, I'm not sure.

MR. PALUTIS: It's a different case. The only thing she got was an e-mail.

MS. COX: Okay.

MR. PALUTIS: It was a pretty generic

looking thing.

MS. COX: No, I spoke with a pharmacist physically about a member having tonsillitis, like in the Lexington area. Or, I'm sorry, having a tonsillectomy, I'm sorry.

The reason behind the Norco Elixir not being covered was due to an FDA recommendation back in January, 2018, where they recommended Hydrocodone and Codeine containing products not be prescribed to people less than age 18. That's where it came from.

MR. PALUTIS: I understand that, but what if that was your child?

MS. COX: My child had surgery before and, I mean, I'm just speaking -- you know, and I get it, I understand completely where she's coming from. But my child has had surgery before and his doctor refused to give him pain medication. He told me give him Tylenol and that would work. And if it didn't, for me to call back. But he said I don't prescribe narcotics for kids. And that was his ophthalmologist.

With that being said, no, I completely understand. Nobody wants their child to be in pain, I completely understand.

MR. PALUTIS: And I'm not sitting here suggesting that every child that has surgery should get Norco Elixir. I mean, I think that there are other measures that can be had. The point the pharmacist was making, and I as a pharmacist agree, is that there may be times when it is necessary.

MS. COX: Uh-huh.

MR. PALUTIS: I'm not -- again, I'm not suggesting that everybody just, you know, goes out the door with a prescription for Norco. But there could be complications that come up during the surgery that would require more -- you know, some more stronger pain management medicine. From what we were told, that Aetna is the only MCO that has that, all the other MCOs allow that.

MS. COX: I can't speak for the other MCOs. But as far as Aetna's concerned, we are aware of the issue, and it has been taken to our committee for review. They haven't made a decision yet as to what they're going to do. But it wasn't us just trying to prevent somebody from being able to get a pain medication, it was taken based on a recommendation.

MR. PALUTIS: No, no, no, right, I mean,

and she was told that. I mean, she was -- I believe it was e-mail, because she forwarded it to me, and that's what she was told was the logic. And while everybody understands the logic, I think everybody also understands that there are times where stuff like that is needed. And for there to not even be an option for the doctor to get it approved was kind of the more disturbing part than anything else.

MS. COX: Well, I thought you said the doctor refused to --

MR. PALUTIS: They said they tried to do the product before for Aetna and it got refused, got turned down.

MS. COX: But do we know the background as to why?

MR. PALUTIS: Well, I mean --

MS. COX: So with Aetna --

MR. PALUTIS: So if the doctor had done a prior authorization, would it have gone through?

MS. COX: I don't know, because it depends on what they submit. And, you know, from a medical director standpoint, they get to make the final decision. So, you know, it's not a pharmacist that gets to -- you know, the

pharmacist can recommend a denial, but at that point it's the medical director's decision. So, I can't say the medical director would say yes or no.

MR. PALUTIS: Right. And I'm not -- I get the reasoning. Again, just from the information that the pharmacist was provided was that there was no chance that this patient could get this covered, so they should either pay cash or not get it. And I think that's the most disturbing part of the story from my perspective. I understand the edit, right, because we don't -- the last thing we want is to have --

MS. COX: Right.

MR. PALUTIS: So, I get it.

MS. COX: But to the point of would it be denied, you cannot always say it would be denied, because it's up to the medical director's professional judgment. And so "A" medical director who got a similar PA before said no; whereas, "B" medical director might see the same PA and say, oh, well, you know, yeah, I'll go ahead and approve it. So from a physician standpoint, to just automatically say, well, I'm never going to ever do it again because I had one

denial --

MR. PALUTIS: Well, I don't agree with that.

MS. ROGERS: To just add to this discussion, I mean, I think especially as we look at opioids and safety, and other drugs like that where we're putting in safeguards to protect the patient, there is always an exception process. Recognizing that, providers may not want to go through that, but that's the only way we know that something is maybe medically necessary, to go through that. And then there's appeals and so forth that allow the patient to, you know --

MS. COX: And to your point, I actually discussed that with the pharmacist I talked to on the phone. And I don't disagree with her, because, you know, to the point that she made about this, well, they've had the surgery now, so while we're going through this whole process we have a child sitting over here in pain. And so I completely -- you know, her concern is legitimate, I don't disagree with that, it's just the way the process is.

But because it was brought up, we are reviewing it. And so if a change is made, we'll

definitely let the PTAC know. But right now it's just under review.

MR. JOSEPH: Can I ask, is it helpful for providers to voice those kind of -- providers, I guess, prescribing providers to voice those kind of concerns at P&T meetings, so it would be MCO P&T meetings, to say, hey, this is something that we see pretty often. I mean, I think that's an appropriate venue for those kind of issues for providers.

I mean, I think this is right for you, Chris. But when a provider is willing to not even start the PA process, that's something easy for you to say go to the P&T committee, start your argument there. I mean, that's -- I don't see why that would be hindering anyone in any way.

MR. PALUTIS: I mean, it's terrible, I mean, for them to say they're not going to do it, I think that's a terrible thing. I'm not sure why a physician's office would do that, but that -- I mean, we get that a lot.

MS. ROGERS: Oh, I'm sure you do.

MR. PALUTIS: And, you know, who's right, who's wrong, I mean, you can't -- whatever. But at the end of the day, where we felt terrible was

the mother left the pharmacy without the pain medicine, and that's the concern. Maybe the kid didn't need it, but maybe the child did, that's the concern.

MS. COX: It's a legitimate concern and that's why we take it extremely seriously. And that's why we have presented it back to our P&T committee to see if we can come up with some type of alternative path for instances where children are getting their tonsils removed, or maybe having a dental extraction or, you know, those type of cases. So, no, we heard her and we're taking it seriously.

MR. PALUTIS: I appreciate it.

MS. COX: I'm just waiting to get a response back.

MS. FRANCIS: Is that like only -- I can't imagine not having any --

MS. COX: The recommendation from the FDA was just Codeine-containing products. And so our P&T took it for face value --

MS. FRANCIS: My son had oral surgery this summer with six teeth cut out. I couldn't imagine him not having -- and he's 15, I mean, you know.

MR. VENNARI: My son had four wisdom teeth

pulled out last year and they would not give him any.

MS. COX: Yeah, it all depends on the doctor. I mean, my aunt is a dentist and she does extractions. And she's been a dentist for almost 40 years. She has never written opioids, she refuses. And I think the American Dental Association, they actually say that studies show or they prefer to use, you know, Extra Strength Tylenol, along with 600, 800 milligrams of Motrin over opioids.

MS. FRANCIS: Yes, but I do also think that there are some situations, like my son, who had three teeth fused into bone, it was going to -- yeah, there's just some surgeries that are more --

MS. COX: Believe me, I understand. I had a bony wisdom tooth extraction, I understand.

MS. FRANCIS: Like he said, a PA should be submitted and --

MS. COX: Right, and let it -- and then it would go through medical director review. But, again, you know, that does pose, you know, I know -- I hate calling a PA a barrier, but that's the way it's viewed as, you know, a barrier to care.

It's an extra hurdle as, you know, it's been described to me, to get the medication, so --

MS. FRANCIS: The other thing we do have to consider is I know that we're supposed to respond in 24 hours, but that child might have been in pain in 3 hours.

MS. COX: Exactly. And that was her point, she said, you know, you have 24 hours to review this PA, but that could potentially be -- you know, if it takes the full 24 hours, that's a whole day before that child would have been able to get medication. So, again, that's why we're looking at it and trying to figure out if there's something we can change in our process to accommodate. Because we're not trying to deny access to care to anybody, but we also want to be safe.

MS. FRANCIS: Sure. And that's why I'm thankful for the Pharmacy TAC, because we do try to say bring these things to light and say, okay, this is a real world example, and I feel like we try to work together.

MS. HUGHES: And just as an opposite side of this, we have the Children's TAC who is working with us on how to prevent opioids from being

prescribed --

MS. FRANCIS: A hundred percent. I'm usually on that --

MS. HUGHES: -- all these drugs from being, so it's --

MS. FRANCIS: Well, that was what Thea said, there is -- this is the general rule and we should follow guidelines, but then there should be a step to when it's legitimate need.

MS. HUGHES: Yeah. And that doctor should have probably, you know, not made a statement I'm not going to just do any more because one was denied.

MR. PALUTIS: I wish I had a nickle for every time I heard that.

MS. COX: This is not just for children needing opioids. I mean, when I was in practice I would hear -- when I would call a physician for a PA, it would be for an adult, and, oh, I just don't do opioid PA. I mean, we hear that all the time. We get members calling in that are adults that, you know, need a prescription for an opioid and they get it, but their doctor won't do the PA. So, they call us like, well, I can't afford it, what am I supposed to do. We call the doctor's

office and they're like, oh, we don't do opioid PAs. Which I kind of thought violated their contract, but --

MS. FRANCIS: May be something for the provider groups to look at.

Okay. Well, I don't believe that, at least from my standpoint, we have any recommendations for the MAC. Any other members' standpoints?

I will be attending next Thursday. I would say that, again, we look at the quality strategy before the next meeting.

And speaking of next meetings, I put the draft schedule on there. Sharley, I think that we were the TAC you changed the day of the week on.

MS. HUGHES: Was it?

MS. FRANCIS: Yeah.

MS. HUGHES: So is that a problem? If it is, I don't --

MS. FRANCIS: I think it might be a problem. I've heard from one member that their off day is Tuesday, so that works. But what about anyone else?

MR. BETZ: That's funny, I wasn't actually the member, but Tuesdays are better for me as

well.

MS. HUGHES: Tuesday's better, okay.

MS. GRAY: Me, too.

MS. HUGHES: I will --

MS. FRANCIS: I mean, I -- yeah, because if you have to staff the pharmacy, you have to staff the pharmacy.

MS. HUGHES: Oh, yeah, I completely understand that. What I was trying to accomplish is that --

MS. FRANCIS: I get it.

MS. HUGHES: -- this week before ends up with about six different TAC meetings -- meeting or TAC meeting. If --

MS. FRANCIS: Can we look at Tuesday before or after these dates?

MS. HUGHES: Either that, or I know that you-all are meeting the month of the TAC, would -- would you be opposed to meeting the month that the TAC -- that the MAC doesn't meet, is that an issue? So, it would just be switching you from meeting January, March, May, July, to February, April -- I mean, I'll look to keep you in the same month and if we can possibly keep you there, but is that an objection if you --

MS. FRANCIS: No. It actually might help, because I might get the minutes --

MS. HUGHES: Yeah, you'll have the minutes and so forth that you can look at quicker, so -- but I'll look at it from that standpoint, too. So, I'll put you back to Tuesday. I just, I honestly could not remember who it was the time I sent that e-mail out.

MS. FRANCIS: So, we'll look for a revised draft on that?

MS. HUGHES: Yeah, right. While we're talking about that topic of meetings, I know in the last little bit this room has gotten a little loud from the folks in the cafeteria. I moved it to here because it is a nicer conference room, it's bigger than what our conference room is. Do you-all have an objection --

MS. FRANCIS: I haven't even noticed it.

MS. HUGHES: Okay, okay.

MS. MILLER: It was just now that I started to notice that, so this is fine.

MS. HUGHES: Okay.

MS. FRANCIS: We try to finish by 11. I try to make it 9:30 to 11.

MS. HUGHES: Okay. I just wanted -- I'm

trying -- because it makes it easier for you-all if you just come in the door and come here. I'm trying to get as many as I can that will fit in here comfortably, it be here rather than having it somewhere else, but --

MS. FRANCIS: Yeah, I would prefer it.

MS. HUGHES: Okay.

MS. MILLER: This is easier, thank you.

MS. FRANCIS: Okay. Well, then I will adjourn if nobody has anything else. Thank you.

(The meeting concluded at 11:06 a.m.)

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STATE OF KENTUCKY)
) SS:
COUNTY OF JEFFERSON)

I, TAMARA DUVALL-McCLAIN, a Notary Public within and for the State at Large, my commission as such expiring on February 13, 2020, do hereby certify that the foregoing meeting of the Pharmacy Technical Advisory Committee was taken before me at the time and place and for the purpose stated; that the meeting was reduced by me to shorthand writing and transcribed by me with the aid of a computer; and that the foregoing is a full, true and correct transcript of the said meeting.

WITNESS my hand this the 1st day of October, 2019.

_____
TAMARA DUVALL-McCLAIN, CCR, RPR
Kentucky CCR No. 20042A138
Notary Public, State at Large
Kentucky Notary ID No. 549592